FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031740

Facility Name: MAR KA NURSING HOME

Address: 201 SOUTH 10TH STREET (Number) MASCOUTAH (City) 62258 (Zip Code)

County: ST CLAIR

Telephone Number: 618-566-8000 **Fax #** ( )

HFS ID Number: 0031740

Date of Initial License for Current Owners: 12/23/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: YVONNE CHUA **Telephone Number:** 636-394-3000

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/04 to 9/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JAMES J GIARDINA
(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) DARRYL E BUEKER, CPA
(Firm Name & Address) BKD, LLP
PO BOX 1190; SPRINGFIELD, MO 65801
(Telephone) 417-865-8701 Fax # 417-865-0682

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 9/23/05

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	23	Skilled (SNF)	76	8,819	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	0	18,921	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,378	2,221	1,823	5,422	8
9	SNF/PED					9
10	ICF	10,428	6,042	1,161	17,631	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,806	8,263	2,984	23,053	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.10%

D. How many bed-hold days during this year were paid by the Department? 1 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/23/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/23/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified ____ and days of care provided ____

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/05 Fiscal Year: 9/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	151,223	15,460	5,530	172,213		172,213		172,213			1
2	Food Purchase		92,918		92,918		92,918	(410)	92,508			2
3	Housekeeping	122,919	14,458		137,377		137,377	196	137,573			3
4	Laundry	25,082	11,575	182	36,839		36,839		36,839			4
5	Heat and Other Utilities			72,006	72,006		72,006		72,006			5
6	Maintenance	37,313	30,054	25,300	92,667		92,667	137	92,804			6
7	Other (specify):*											7
8	**TOTAL General Services**	336,537	164,465	103,018	604,020		604,020	(77)	603,943			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,036,254	138,280	2,653	1,177,187		1,177,187	19,449	1,196,636			10
10a	Therapy			152,828	152,828		152,828		152,828			10a
11	Activities	40,611	5,202	2,899	48,712		48,712		48,712			11
12	Social Services	26,265	26	1,751	28,042		28,042		28,042			12
13	CNA Training			1,185	1,185		1,185		1,185			13
14	Program Transportation			35	35		35		35			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,103,130	143,508	167,351	1,413,989		1,413,989	19,449	1,433,438			16
	C. General Administration											
17	Administrative	52,290			52,290		52,290	10,139	62,429			17
18	Directors Fees											18
19	Professional Services			89,656	89,656		89,656	(70,863)	18,793			19
20	Dues, Fees, Subscriptions & Promotions			23,272	23,272		23,272	(4,455)	18,817			20
21	Clerical & General Office Expenses	45,650	9,514	26,858	82,022		82,022	43,670	125,692			21
22	Employee Benefits & Payroll Taxes			283,688	283,688		283,688	12,208	295,896			22
23	Inservice Training & Education			3,955	3,955		3,955		3,955			23
24	Travel and Seminar			3,596	3,596		3,596	6,014	9,610			24
25	Other Admin. Staff Transportation							120	120			25
26	Insurance-Prop.Liab.Malpractice			51,291	51,291		51,291	55	51,346			26
27	Other (specify):*											27
28	**TOTAL General Administration**	97,940	9,514	482,316	589,770		589,770	(3,112)	586,658			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,537,607	317,487	752,685	2,607,779		2,607,779	16,260	2,624,039			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MAR KA NURSING HOME #0031740 **Report Period Beginning:** 10/1/04 **Ending:** 9/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			31,274	31,274		31,274	42,222	73,496			30
31	Amortization of Pre-Op. & Org.							181	181			31
32	Interest							48,346	48,346			32
33	Real Estate Taxes			36,351	36,351		36,351		36,351			33
34	Rent-Facility & Grounds			182,400	182,400		182,400	(171,909)	10,491			34
35	Rent-Equipment & Vehicles			879	879		879	2,412	3,291			35
36	Other (specify):*											36
37	**TOTAL Ownership**			250,904	250,904		250,904	(78,748)	172,156			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			41,610	41,610		41,610		41,610			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,537,607	317,487	1,045,199	2,900,293		2,900,293	(62,488)	2,837,805			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(465)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(410)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,275)	21		18
19	Entertainment	(228)	24		19
20	Contributions	(1,363)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,692)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(915)	20		28
29	Other-Attach Schedule	(380)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (14,728)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(47,760)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (47,760)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (62,488)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		3,190	10.2	42
43	Prescription Drugs	X		81,737	10.2	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 84,927		47

STATE OF ILLINOIS

MAR KA NURSING HOME

ID# 0031740

Report Period Beginning: 10/1/04

Ending: 9/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISCELLANEOUS INCOME	$ (380)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(380)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MAR KA NURSING HOME # 0031740 **Report Period Beginning:** 10/1/04 **Ending:** 9/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(410)	0	0	0	0	0	0	0	0	0	0	(410)	2
3	Housekeeping	0	0	196	0	0	0	0	0	0	0	0	196	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	137	0	0	0	0	0	0	0	0	137	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(410)	0	333	0	0	0	0	0	0	0	0	(77)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	19,449	0	0	0	0	0	0	0	0	0	19,449	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	19,449	0	0	0	0	0	0	0	0	0	19,449	16
	C. General Administration													
17	Administrative	0	10,139	0	0	0	0	0	0	0	0	0	10,139	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(70,863)	0	0	0	0	0	0	0	0	0	(70,863)	19
20	Fees, Subscriptions & Promotions	(4,607)	0	152	0	0	0	0	0	0	0	0	(4,455)	20
21	Clerical & General Office Expenses	(9,018)	52,688	0	0	0	0	0	0	0	0	0	43,670	21
22	Employee Benefits & Payroll Taxes	0	12,208	0	0	0	0	0	0	0	0	0	12,208	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(228)	6,242	0	0	0	0	0	0	0	0	0	6,014	24
25	Other Admin. Staff Transportation	0	0	120	0	0	0	0	0	0	0	0	120	25
26	Insurance-Prop.Liab.Malpractice	0	0	55	0	0	0	0	0	0	0	0	55	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,853)	10,414	327	0	0	0	0	0	0	0	0	(3,112)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,263)	29,863	660	0	0	0	0	0	0	0	0	16,260	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **MAR KA NURSING HOME** **# 0031740** **Report Period Beginning:** **10/1/04** **Ending:** **9/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	42,222	0	0	0	0	0	0	0	0	0	42,222	30
31	Amortization of Pre-Op. & Org.	0	181	0	0	0	0	0	0	0	0	0	181	31
32	Interest	(465)	48,811	0	0	0	0	0	0	0	0	0	48,346	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(171,909)	0	0	0	0	0	0	0	0	0	(171,909)	34
35	Rent-Equipment & Vehicles	0	2,412	0	0	0	0	0	0	0	0	0	2,412	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(465)	(78,283)	0	0	0	0	0	0	0	0	0	(78,748)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,728)	(48,420)	660	0	0	0	0	0	0	0	0	(62,488)	45

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J GIARDINA	100	WEST MAIN NURSING HOME	MASCOUTAH	COMMUNITY		
JAMES J GIARDINA	100	MONMOUTH NURSING HOME	MONMOUTH	CARE CTRS, INC	BALLWIN, MO	HOME OFFICE
				RISA	JEFFERSON CITY, MO	W/C INS
				IMPEDIA	JEFFERSON CITY, MO	LIAB INS

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	BUILDING RENT	$ 182,400	JAMES J GIARDINA	100.00%	$	$ (182,400)	1
2	V	30	DEPRECIATION		JAMES J GIARDINA	100.00%	42,222	42,222	2
3	V	32	INTEREST EXPENSE		JAMES J GIARDINA	100.00%	48,811	48,811	3
4	V	31	AMORTIZATION		JAMES J GIARDINA	100.00%	181	181	4
5	V	19	HOME OFFICE	73,440	COMMUNITY CARE CENTERS, INC	COMMON		(73,440)	5
6	V	34	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	10,491	10,491	6
7	V	35	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	2,412	2,412	7
8	V	10	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	19,449	19,449	8
9	V	17	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	10,139	10,139	9
10	V	21	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	52,688	52,688	10
11	V	22	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	12,208	12,208	11
12	V	19	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	2,577	2,577	12
13	V	24	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	6,242	6,242	13
14	Total			$ 255,840			$ 207,420	$ * (48,420)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	HOME OFFICE/MGMT FEES	$	COMMUNITY CARE CENTERS, INC	COMMON	$ 120	$ 120	15
16	V	6	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	137	137	16
17	V	20	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	152	152	17
18	V	26	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	55	55	18
19	V	3	HOME OFFICE/MGMT FEES		COMMUNITY CARE CENTERS, INC	COMMON	196	196	19
20	V	22	WORKERS COMP INS	90,755	RISA	25.00%	90,755		20
21	V	26	LIABILITY INS	45,138	IMPEDIA	100.00%	45,138		21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 135,893			$ 136,553	$ * 660	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	JAMES J GIARDINA	PRESIDENT	GENERAL DIR.	100.00	NONE	4	8.00	SALARY	$ 6,350	17.7	1
2	BETTY HUGHES	SECRETARY		0.00	NONE	3	6.52	SALARY	3,789	17.7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,139		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: COMMUNITY CARE CENTERS, INC
Street Address: 312 SOLLEY DRIVE - REAR
City / State / Zip Code: BALLWIN, MO 63021
Phone Number: (636-394-3000
Fax Number: (636-394-7713

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	HOME OFFICE	DIRECT COST			$	$		$	1
2		WEST COUNTY CARE CENTER						5,226,170	204,040	2
3		ST GENEVIEVE CARE CTR						2,276,178	83,017	3
4		CCC OF LEMAY						2,209,896	77,382	4
5		SALEM CARE CENTER						1,784,077	66,551	5
6		MONMOUTH NH						2,119,149	72,051	6
7		MAR-KA NH						2,826,853	116,866	7
8		WEST MAIN NH						344,196	11,798	8
9		CCC OF SENECA						2,458,662	90,264	9
10		MT VERNON PLACE CARE						2,510,965	85,740	10
11		COUNTRY VIEW NH						1,936,002	77,926	11
12		MERAMEC NH						2,678,946	118,210	12
13		SEVILLE CARE CENTER						2,596,921	90,895	13
14		SALEM RES CARE						540,419	18,084	14
15		BOSS RES CARE						130,669	4,372	15
16		CARL JUNCTION RES CARE						626,569	20,967	16
17		MT VERNON RES CARE						429,610	14,375	17
18		SENECA HOME PLACE						444,391	14,870	18
19		HUDSON HOUSE						482,781	16,155	19
20		MAPLE GROVE LODGE						2,559,000	113,915	20
21		CCC OF AURORA						4,079,498	137,650	21
22		BARRY COMMUNITY CARE						2,169,252	76,023	22
23		LICKING RES CARE						259,092	8,671	23
24		COMMUNITY IN HOME						673,248	29,379	24
25	TOTALS					$	$		$ 1,549,201	25

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MAR KA NURSING HOME **#** 0031740 **Report Period Beginning:** 10/1/04 **Ending:** 9/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 23,670	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 33,921	2
3. Under or (over) accrual (line 2 minus line 1).	$ 10,251	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 26,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 36,351	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	27,565	8
2001	28,534	9
2002	29,087	10
2003	31,500	11
2004	33,921	12

ACCRUAL - $33,921 x 9/12 = 25,441 + MISC DIFF 659 = $26,100

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAR KA NURSING HOME COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0031740

CONTACT PERSON REGARDING THIS REPORT YVONNE CHUA

TELEPHONE 636-394-3000 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-31.01-114-007	LOT/SEC-31-SUBL/TWP-1N-	$ 33,610.00	$
2.		BLK/RG-6W PT LOT 12C	$	$
3.		AS IN BK 2659-1974	$	$
4.	10-31.0-113-009	LOT/SEC-18 BK 2659-1974	$ 176.00	$
5.	10-31.0-114-009	LOT/SEC-31-SUBL/TWP-1N-	$ 135.00	$
6.		BLK/RG-6W BK 2659-1974	$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 33,921.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,425 B. General Construction Type: Exterior BRICK Frame STEEL REINFORCE Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	48,000	Dec-86	$ 75,000	1
2					2
3	TOTALS	48,000		$ 75,000	3

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1986	1970	$ 950,000	$	22.5	$ 42,222	$ 42,222	$ 763,352	4
5			1986		14,621		10			14,621	5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF REPAIR			1989	4,686		10			4,686	9
10	PATIO AND RAMP			1991	3,252		12			3,252	10
11	PATIO ROOF			1991	2,890		10			2,890	11
12	FLAT ROOF			1991	14,000		10			14,000	12
13	ROOF (NORTH WING)			1992	10,000		10			10,000	13
14	ROOF REPAIR			1990	7,055		10			7,055	14
15	SIDING REPAIR			1990	4,276		10			4,276	15
16	CARPET --- DISPOSED			1993			5				16
17	SPRINKLER SYSTEM			1993	2,168	87	25	87		1,048	17
18	BULLOCK GARAGES			1993	7,176	478	15	478		5,662	18
19	5 TON REFRIGERATION UNIT			1995	3,814		10			3,814	19
20	ROOF REPAIR			1995	18,785	1,120	10	1,120		18,785	20
21	LANDSCAPING - PATIO			1995	3,342	334	10	334		3,313	21
22	ROOFING REPAIR			1997	12,732	1,273	10	1,273		10,820	22
23	AIR CONDITIONING			1997	3,760	376	10	376		3,004	23
24	PHONE SYSTEM			1998	3,780	378	10	378		2,867	24
25	ELECTRICAL WORK			1999	3,613	181	20	181		1,219	25
26	COUNTERTOPS			1999	2,127	106	20	106		700	26
27	LENNOX 7.5 ROOFTOP UNIT			2000	5,733	573	10	573		3,440	27
28	ROOF ON EAST ASH WING			2000	6,400	640	10	640		3,466	28
29	MECHANICAL ROOM IMPR			2001	23,797	1,587	15	1,587		7,265	29
30	FIRE DAMPERS IN DUCT WORK			2001	1,900	127	15	127		496	30
31	FIRE DAMPERS IN DUCT WORK			2001	3,059	204	15	204		782	31
32	EXTERIOR KITCHEN DOORS			2002	1,567	78	20	78		294	32
33	RE-PLATE DOORS			2002	9,398	940	10	940		3,289	33
34	GAS WATER HEATER			2002	6,235	624	10	624		2,130	34
35	MIXING VALVE HOT WATER TAN			2002	1,143	114	10	114		324	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SEWAGE MOTOR EJECTOR PU	2003	$ 1,567	$ 157	10	$ 157	$	$ 379	37
38	2 REMINGTON 9000BTU A/C'S	2003	1,135	227	5	227		548	38
39	2 REMINGTON 9000BTU A/C'S	2003	1,135	227	5	227		548	39
40	1 REMINGTON 9000BTU A/C'S	2003	566	112	5	112		260	40
41	5TON ROOFTOP A/C UNIT	2003	5,471	547	10	547		1,322	41
42	KATOLIGHT GENERATOR	2004	20,641	4,128	5	4,128		6,536	42
43	RE-PAVE PARKING LOT-GRAVEL	2004	5,470	1,094	5	1,094		1,368	43
44	CARPET FOR OFFICES	2005	1,036	155	5	155		155	44
45	UPGRADE WANDERGUARD SYST	2005	4,997	167	10	167		167	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,173,327	$ 16,034		$ 58,256	$ 42,222	$ 908,133	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 155,366	$ 12,893	$ 12,893	$	VARIOUS	$ 95,245	71
72	Current Year Purchases	20,769	2,347	2,347		VARIOUS	2,347	72
73	Fully Depreciated Assets							73
74	DISPOSED	(5,275)						74
75	TOTALS	$ 170,860	$ 15,240	$ 15,240	$		$ 97,592	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NONE			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,419,187	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 31,274	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 73,496	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 42,222	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,005,725	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	RETAINER FEE	$ 5,000	92
93			93
94			94
95		$ 5,000	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: RELATED PARTY COSTS
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 879 Description: Phone System - $833; Truck Rental - $46
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER CNA 85

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 42

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 405	$ 780	$	$ 1,185
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$ 405	$ 780	$	$ 1,185
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,185			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	825	$	53,362	$	825	$ 53,362	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		221		13,890		221	13,890	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a.3	hrs		1,333		85,576		1,333	85,576	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	2,379	$	152,828	$	2,379	$ 152,828	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MAR KA NURSING HOME **#** 0031740 **Report Period Beginning:** 10/1/04 **Ending:** 9/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 93,152	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27,100)	417,979		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	4,201		5
6	Prepaid Insurance	33,179		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due To/From Rel Parties	(986,378)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (437,867)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	197,377		15
16	Equipment, at Historical Cost	170,860		16
17	Accumulated Depreciation (book methods)	(216,423)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP & DEPOSITS	33,689		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 185,503	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (252,364)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 112,023	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,607		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,621		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,067		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To/From Rel Parties	21,291		36
37	Due To Medicaid	1,444		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 265,153	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 265,153	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (517,517)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (252,364)	$	48

***(See instructions.)**

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (108,702)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (108,702)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(348,815)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **PY AUDIT AJE - ALLOW FOR D/A**	(60,000)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (408,815)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (517,517)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,904,261	1
2	Discounts and Allowances for all Levels	(1,906,233)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,998,028	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	381,824	6
7	Oxygen	169,942	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 551,766	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	839	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 839	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	465	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 465	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	380	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 380	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,551,478	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	604,020	31
32	Health Care	1,413,989	32
33	General Administration	589,770	33
	B. Capital Expense		
34	Ownership	250,904	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	41,610	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,900,293	40
41	**Income before Income Taxes (line 30 minus line 40)****	(348,815)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (348,815)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,985	2,113	$ 43,795	$ 20.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,929	4,345	80,455	18.52	3
4	Licensed Practical Nurses	24,805	26,121	399,024	15.28	4
5	CNAs & Orderlies	49,921	51,991	498,067	9.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,201	2,249	21,527	9.57	9
10	Activity Assistants	1,862	1,910	19,084	9.99	10
11	Social Service Workers	2,130	2,218	26,265	11.84	11
12	Dietician					12
13	Food Service Supervisor	2,015	2,125	21,407	10.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,267	4,431	33,784	7.62	15
16	Dishwashers	11,410	12,006	96,032	8.00	16
17	Maintenance Workers	3,348	3,513	37,313	10.62	17
18	Housekeepers	13,034	13,992	122,919	8.78	18
19	Laundry	3,440	3,648	25,082	6.88	19
20	Administrator	2,040	2,120	52,290	24.67	20
21	Assistant Administrator					21
22	Other Administrative	3,046	3,119	45,650	14.64	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,525	1,565	14,913	9.53	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,958	137,466	$ 1,537,607 *	$ 11.19	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	158	$ 5,530	1.3	35
36	Medical Director	48	6,000	9.3	36
37	Medical Records Consultant	42	1,453	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,200	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	1,751	11.3	44
45	Social Service Consultant	33	1,751	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	362	$ 17,685		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AIMEE COUCH	ADMINISTRATOR	0	$ 52,290
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 52,290

B. Administrative - Other

Description	Amount
NONE	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
COMMUNITY CARE CENTERS, INC	MGMT FEES	73,440
BKD, LLP	ACCOUNTING	10,128
HUSCH & EPPENBERGER	LEGAL	31
VAN OSTRAND & ELVIDGE	LEGAL	6,057
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 89,656

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,755
Unemployment Compensation Insurance	
FICA Taxes	142,141
Employee Health Insurance	43,615
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	5,751
OSHA EMPLOYEE BENEFITS	68
401K CONTRIBUTIONS	1,358
HOME OFFICE ALLOCATION	12,208
TOTAL (agree to Schedule V, line 22, col.8)	$ 295,896

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,782
Health Care Worker Background Check (Indicate # of checks performed 78)	935
DUES & SUBSCRIPTIONS	3,061
TAXES & LICENSES	6,887
ADVERTISING OTHER	4,606
HOME OFFICE ALLOCATION	152
Less: Public Relations Expense	( )
Non-allowable advertising	(3,691)
Yellow page advertising	(915)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,817

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,368
MEALS	228
Seminar Expense	
HOME OFFICE ALLOCATION	6,242
Entertainment Expense	(228)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,610

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MAR KA NURSING HOME # 0031740 Report Period Beginning: 10/1/04 Ending: 9/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2	NONE												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MAR KA NURSING HOME # 0031740 **Report Period Beginning:** 10/1/04 **Ending:** 9/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HCA $4,172**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **3-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **41,610**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **19%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BKD, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **TO BE SENT WHEN COMPLETED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **N/A**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.